KCDRB Form #3

STATEMENT OF PHYSICIAN-PROVIDER TREATING EMPLOYEE

MEMO TO: King County Disability Retirement Board
Exchange Bldg., MS: EXC-ES-0300
821 Second Avenue
Seattle, Washington 98104 – 1589

FROM: Dr.'s name _____

Title: _____

Address: _____

_____

Phone #: _____

RE: _____

LEOFF-I Member/applicant for disability/retirement benefits.

I have examined and treated the above named LEOFF-I member for the following disability illness or injury: (attach more information if necessary)

The cause of the illness or injury was: (attach more information if necessary)

[__] I HAVE READ a description of the member's job duties provided by the member, or the member has described to me the regular duties of his/her position.

[__] I WAS NOT PROVIDED a description of the member's job duties by the member at the time I signed this affidavit.

[__] I have attached an additional statement/letter containing the following information:

a) A description of the disability claimed and the effect of the disability on the member's ability to perform the duties of his/her position with average efficiency.
b) A summary of any prior treatment of the condition and the results of such treatment.
c) A description of present treatment, if any.
d) Prognosis, including the date the member can be expected to return to duty.

"I understand this affidavit is being provided in order to justify this member's eligibility for LEOFF-I disability/retirement leave benefits."

_____

Signature of Physician/ Health Provider Date